Newborn Patient Profile

Patient Information:

Patient's Name:_____ Sex: [ ]M [ ]F DOB: _____ SSN#_____

Address: _____ City: _____ State: ____ Zip: _____

Ethnicity: _____ Race _____

☆**Text Message or Email for Appointment Reminders?** Text (cell phone) _____ or Email:_____

Siblings Name:	Sibling's DOB:	Siblings Sex:	Siblings Ethnicity:	Siblings Race:

Primary Guardian/Financially Responsible:

Name: _____ Phone # _____ [ ]Home [ ]Work [ ]Cell

Address: _____ Email Address: _____

City, State/Zip: _____ Employer: _____

Date of Birth: _____ Social Security #: _____

Insurance Information

Relation to Patient: _____

Insurance Company: _____ Policy #: _____

Address: _____ Group #: _____

City/State/Zip: _____ Copay: _____

Other Parent/Guardian Contact Information:

Name: _____ Phone#: _____ [ ]Home [ ]Work [ ]Cell

Address: _____ Employer: _____

City, State/Zip: _____ Social Security #: _____

Date of Birth:

Insurance Information

Relation to Patient: _____

Insurance Company: _____ Policy #: _____

Address: _____ Group #: _____

City, State/Zip: _____ Copay: _____

Important Contacts:

Name: _____ Phone: _____ Relationship: _____

_____ Phone: _____ Relationship: _____

☆**Preferred Pharmacy: _____ Address: _____ Phone #: _____**

***Insurance Coverage is a contract between you and your insurance company. It is your responsibility to know what your plan does and does not cover.**

***We will file insurance claims for you, but you are responsible for amounts not paid by insurance within 90 days.**

***I understand that I am responsible for any balance not covered by insurance. I also understand that all co-payments, deductibles and co-insurances are due at the time of service.**

***As parent or legal guardian, I authorize payment of medical benefits to be made directly to Pediatric & Adolescent Associates, PSC for services performed. I further agree to be fully responsible for all lawful debts incurred for services provided.**

***I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to our account with Pediatric & Adolescent Associates, PSC.**

_____ _____

Signature of Parent/Guardian **Date**